

Provider Appeal/Reconsideration Request

Chart Notes Required for Preauthorization Denial Appeals/Reconsiderations

Please fax to 503.765.9675 | Questions call 971.345.5933 or 833.257.2192

Member Information			
Last Name:		First Name:	
Insurance ID #:		DOB:	
Address:		,	
REQUIRED Contact Information			
Name:		Phone:	Fax:
Requesting Provider:			TIN#:
Servicing Provider:			TIN#:
Servicing Facility:			TIN#:
Reconsideration Request Type:			
☐ Preauthorization Denial Preauthorization Date:			
ICD-10 Code(s):	CPT Code(s):		Requested Item/Service:
Reconsideration Request Type:			
☐ Claim Denial Claim Number:			
Reconsideration Comments:			

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